

## MANUAL BACKUP FORM – WOMAN

**WIC Service Provided**    ☐ NC    ☐ RC    ☐ RD    ☐ F/U    ☐ NEi    ☐ NE+    ☐ MC    ☐ Other

**Date WIC Service Provided:** \_\_\_\_\_ **Is the client physically present?** ☐ Yes ☐ No

### Demographics, Residency and ID Proofs

Client Name:	Category	DOB	Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Racial Background
Caregiver Name	DOB	Alternate Name		DOB
<b>Proof of ID</b>				
<b>Proof of Residency</b>		Proof of ID <input type="checkbox"/> Self-Declared <input type="checkbox"/> Proof Pending Proof of Residency <input type="checkbox"/> Self-Declared <input type="checkbox"/> Proof Pending		
Telephone Number		Telephone Notes/Message Telephone		
Cell Phone Number		Carrier		
Email		Receive Appointment Reminders <input type="checkbox"/> Email <input type="checkbox"/> Text (Phone)		
Street Address		City		Zip Code
Mailing Address		City		Zip Code
Primary Language		Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No		Migrant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Card Number issued		<input type="checkbox"/> Print Letters in Spanish <input type="checkbox"/> Interpreter		WEB IZ: <input type="checkbox"/> Allowed <input type="checkbox"/> Not Allowed

### INCOME INFORMATION    Client is Income Eligible ☐    Client is not Income Eligible ☐

<b>Adjunctive Eligibility:</b> <input type="checkbox"/> Food Assistance Program <input type="checkbox"/> TANF <input type="checkbox"/> Medicaid <input type="checkbox"/> FDPIR	Adjunctive Income Proof:	Number in Family:
<input type="checkbox"/> Applicant is a member of a family in which there is a pregnant woman who is receiving or participating in Medicaid. <input type="checkbox"/> Applicant is a member of a family in which there is an infant who is receiving or participating in Medicaid.		
Source Description(s):		
Period: <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice/Month <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Annually <input type="checkbox"/> Intermittent <input type="checkbox"/> Hourly - # Hours per week _____		Amount: \$ _____
<b>Proof of Income</b>	Other Income Information <input type="checkbox"/> Self-Declared <input type="checkbox"/> Zero Income <input type="checkbox"/> Proof Pending	Note
<b>Additional Notes</b>		

### OTHER DOCUMENTATION

Voter Registration: <input type="checkbox"/> Already Registered <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Eligible To Vote <input type="checkbox"/> No, Does Not Want to Register <input type="checkbox"/> Yes, Wants to Register	
Basic Contact Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Referrals: <input type="checkbox"/> KanCare <input type="checkbox"/> Food Assistance Program <input type="checkbox"/> TANF <input type="checkbox"/> Child Support Enforcement Other _____

**HEALTH INTERVIEW INFORMATION for BF or PP Woman**

Vitamins/Minerals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Folic Acid <input type="checkbox"/> Iron <input type="checkbox"/> Other:		Most Recent Pregnancy and Delivery
		• Estimated Due Date: • Pregnancy End Date:
• Did you develop diabetes during any previous PG? • Do you currently have diabetes? • Do you currently have pre-diabetes? • Did you develop high BP or pre-high BP ( $\geq 130/80$ ) during your most recent PG including PG induced hypertension? • Do you currently have high BP or pre-high BP ( $\geq 130/80$ )? • Have you had preeclampsia during any previous pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	• # of infants this Delivery: • Delivery Method: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section • First Prenatal Visit Date: • Month Prenatal Care Began: • Average number of vitamins per week in the month before Pregnancy: • Pregnancy Complications: • Delivery Complications: • Feeding History:
Pregnancy and Delivery History # of previous pregnancies: Last pregnancy end date:		Birth Outcomes this Delivery: Outcome: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown Outcome: <input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown

**HEALTH INTERVIEW INFORMATION for PG Woman**

Vitamins/Minerals used in the past month <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Folic Acid <input type="checkbox"/> Iron <input type="checkbox"/> Other: Avg number of vitamins per week in the month before pregnancy:		
• Do you have diabetes when you are not pregnant? • Did you develop diabetes during this pregnancy? • Did you develop diabetes during a previous PG? • Do you have high BP or pre-high BP ( $\geq 130/80$ ) when you are not pregnant? • Did you develop high BP or pre-high BP ( $\geq 130/80$ ) during this pregnancy including PG induced hypertension? • Have you had preeclampsia during any previous pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Pregnancy Estimated Due Date: First Prenatal Visit Date: Month Prenatal Care Began: Pregnant with multiples? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Provider:	Pregnancy and Delivery History Number of previous pregnancies: Last Pregnancy End Date:	
Education		

**ATOD**

Alcohol Intake Prior to PG: # Days per Week ____ # Drinks per Day ____ Last Trimester: # Days per Week ____ # Drinks per Day ____ (BF & PP only) Now: # Days per Week ____ # Drinks per Day ____	Illegal Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette Use Prior to PG: <input type="checkbox"/> Did not smoke <input type="checkbox"/> Smoked ____ # cig/day <input type="checkbox"/> Unknown or refused to answer Last Trimester: <input type="checkbox"/> Did not smoke <input type="checkbox"/> Smokes ____ # cig/day <input type="checkbox"/> Unknown or refused to answer Now: <input type="checkbox"/> Did not smoke <input type="checkbox"/> Smokes ____ # cig/day <input type="checkbox"/> Unknown or refused to answer	
Smoking Changes During Pregnancy <input type="checkbox"/> Did not stop smoking <input type="checkbox"/> N/A, did not smoke <input type="checkbox"/> Increased smoking <input type="checkbox"/> Started smoking <input type="checkbox"/> Stopped smoking completely <input type="checkbox"/> Tried to stop but failed <input type="checkbox"/> Unknown/Refused	

MEASUREMENTS			
Height	Weight	Pre-Pregnancy Weight	HGB/HCT
Reason blood work is missing:			
Weight at Delivery (BF/PP)	Total Weight Gain (BF/PP)	BMI	
Measurement Notes			
ASSIGNED RISKS			
Risk		Risk	
Risk		Risk	
<input type="checkbox"/> Professional Discretion High Risk		<input type="checkbox"/> Doctor Diagnosed Medical Condition	
NUTRITION EDUCATION			
Topics Discussed		Handouts Given	
Client Goal	Ways To Meet Goal	Staff Recommendations	
Notes:			
NEXT APPOINTMENT			
<b>Benefits &amp; Appointment Notice</b> <input type="checkbox"/> Mailed card <input type="checkbox"/> Food Benefit Appt _____(date) Next Appt Date/Time_____		Food Package to Assign      Any tailoring needed?	
Form Completed By: _____ Date _____		Data entered into KWIC By: _____ Date _____	

Rev 9/17